

# Accident / Incident Report      Closed



Unit/Department	Process Area	Site	Report Number
South Operation-Elyria		ELYRIA	0084-SOPS-15-0014
Report Date	Incident Date	Incident Time	Copied From
02/03/2015	02/03/2015	12:40 AM	
Incident Location	Team Leader / Supervisor	Reported By	
Building 9	Terrence M Vanderbosch	Alexander Donald	
Title of Event (Limit to 90 characters)	Category	Division / Bus. Group / Subgroup Code	
PK blender lid pressurized and came off.	<input type="checkbox"/> Safety & Health <input type="checkbox"/> Environmental	CC / G-CCP	

## Incident Classification

<input checked="" type="checkbox"/> Near Miss	<input type="checkbox"/> Property Loss	<input type="checkbox"/> Contractor
<input type="checkbox"/> Process Safety	<input type="checkbox"/> Citation / NOV	<input type="checkbox"/> Contractor Injury / Illness
<input type="checkbox"/> Injury / Illness	<input type="checkbox"/> Health Exposure	<input type="checkbox"/> Contract Injury / Illness
<input checked="" type="checkbox"/> Spill / Release	<input type="checkbox"/> Inspection	<input type="checkbox"/> PSM
<input type="checkbox"/> Permit / Regulatory Deviation	<input type="checkbox"/> Major Incident	<input type="checkbox"/> Plant Upset
<input type="checkbox"/> Fire	<input type="checkbox"/> Non-Occupational	<input type="checkbox"/> EHS Management System Failure
<input type="checkbox"/> Odor Complaint	<input type="checkbox"/> RMP	<input type="checkbox"/> Other

## Describe Event / What Happened

An operator finished making a batch of Selexsorb on the PK blender. When the operator opened the valve to discharge the product into the bag nothing came out. The operator opened and closed the valve a few times and still no powder came out. The operator then went up to the top lid of the PK blender and began to slowly loosen it. After the second turn of the screw assembly the lid came off of the blender in the direction of the operator, hitting the support bar and also striking the operator's hard hat, covering him with material. The operator did not sustain any injuries.

## Immediate Corrective Action or Response

Supervisor sent the operator to take a shower and get cleaned up. Had two other operators clean the area after allowing the dust to settle in the room.

## Immediate Cause

Pressure build up in blender from making a batch.

Spill Release Type(s)	Non RQ Spill / Release						
Chemical(s) Involved	CAS #	Phy. State	Air	Land	Water	Contmt	Units
Selectsorb	N/A	Dust	0	0	0	30	lbs
Disposition of Material	Materials cleaned up and disposed of						
Weather Conditions	Skies:	Temperature:	Wind Direction:	Wind Speed:			

## Cause Narrative

Pressure build up inside of blender due to discharge valve not opening while attempting to unload batch.

Contributing Causes	Root/Primary Causes		
Control panel readout did not match valve position	138 - Human Factors Engineering	140 - Workplace Layout	143 - Control/Display Integration/Arrangement LTA
System cannot detect pressure is present	138 - Human Factors Engineering	160 - Intolerant System	161 - Errors Not Detectable
Working batch sheet does not have all of the precautions that the manufacturing document has	111 - Procedures	117 - Misleading/Confusing	118 - Format Confusing or LTA
current tab allows lid to slide off	15 - Design Input/Output	16 - Design Input LTA	16 - Design Input LTA

<b>Explanation of Root Causes</b>	
<b>143</b>	there is an air line to the valve that was not opened. The panel indicator noted that the valve was in the open position, however, with the air off the valve did not open. The controls are not interlocked
<b>161</b>	currently cannot detect that pressure is in vessel. There is no indication of pressure. The operator loosen the lid in a normal fashion and pressure did not vent before the lid came off.
<b>111</b>	The Batch sheet does not have all of the warnings that are specified in the Manufacturing document regarding possible pressure buildup
<b>16</b>	The current lid design does not allow the to be easily retained to the vessel

Any known or potential off-site impacts?	No	PSM Incident?	No	Estimated Cost:	2,000.00 USD
Investigation Team	John R Crawford; Leon Zavodnik; Alexander Donald; Seth Diewald; John Bodmann; Brian Beller; Terrence M Vanderbosch; Noemi Trent; Sean M Holly				

Item	Corrective Action(s) to prevent recurrence	Responsible Person	Target Date	Final Closed Date	VC Req	VE Req
1	Allocate resources to redesign current valve to allow for feedback on valve position with appropriate interlocks to ensure valve is open	Raymond Hazlerig/NA/BASF	08/05/2015	08/03/2015	N	N
2	Investigate if pressure monitoring can be installed on blender so operator knows that pressure has built up	Raymond Hazlerig/NA/BASF	10/05/2015	09/29/2015	N	N
3	Modify batch sheets for appropriate warnings and actions to take during batch processing to ensure blender does not pressurize	John Bodmann/BASF-CATALYSTS/BASF	02/19/2015	02/16/2015	N	N
4	Redesign lid and tabs to prevent lid from popping off if pressure builds up. See if lid can be attached to lip of blender	Brian Beller/NA/BASF	03/27/2015	02/12/2015	N	N
5	Review and Modify PK operating procedures to account for the possibility of pressure in the vessel	John Bodmann/BASF-CATALYSTS/BASF	06/05/2015	06/04/2015	N	N
6	Modify all batch sheets for PK products that describe that venting through top port should occur ( Cr-0218P, etc). Change sheets to stop this practice	John Bodmann/BASF-CATALYSTS/BASF	06/25/2015	06/24/2015	N	N
7	Modify all batch sheets for PK products that describe that venting through top port should occur if applicable ( Pill mix). Change sheets to stop this practice	Justin Quach/NA/BASF	06/25/2015	03/16/2015	N	N

<b>Approved By:</b>	
Manager / Dept. Head	Leon Zavodnik 02/19/2015 10:55 AM
EHS Unit Coordinator	Dean R Gadoury 02/19/2015 10:59 AM
<b>Confidential</b>	

















